III. MEDICAID ADMINISTRATIVE MATCH: LOCAL HEALTH JURISDICTIONS PROCESS OVERVIEW

STEP 1: Local Health Jurisdiction (LHJ) claiming units that choose to participate in the Medicaid Administrative Match (MAM) program first enter into a contract with the Medical Assistance Administration (MAA). This contract is called an Interlocal Agreement.

STEP 2: The LHJ claiming unit appoints a MAM coordinator. The coordinator attends training sessions on the time survey and activity codes before the LHJ may participate in the program. The coordinator and, as appropriate, a designated fiscal staff person in the LHJ must attend invoice training before the first invoice (the A-19) is submitted. Contractors of LHJ claiming units must be trained by their LHJs prior to participating, and invoices must be submitted through the LHJ claiming unit.

STEP 3: The LHJ claiming unit coordinator determines which staff will participate in the random moment time survey and which staff will use the direct charge method. Staff who qualify as Skilled Professional Medical Personnel are identified and complete necessary forms. Job descriptions are reviewed to ensure SPMP status is required. Duty statements are developed for all job classes participating in the time survey. A training schedule is developed and implemented, so that all participating staff are trained prior to their first time survey, and annually thereafter. Information is provided to implement the random moment time survey; staff doing direct charge are trained on how to report their activities on a daily basis. The coordinator trains staff on how to complete Quality Assurance documentation and reviews this documentation on a regular basis.

STEP 4: The coordinator or other staff, as appropriate, develop a procedure to collect information on the number of clients served by the claiming unit. At a minimum, the information collected will include first and last name, middle initial (if available), date of birth, and gender of all clients served by the claiming unit in the calendar quarter prior to the quarter for which a claim will be submitted. The Medicaid ID number (the PIC) may also be collected. This client data is collected quarterly and sent to WSALPHO to be aggregated and forwarded to MAA in order to determine the quarterly Medicaid Eligibility Rate (MER) for each claiming unit and then to return the eligibility data to the claiming unit.

STEP 5: The quarterly invoice is prepared, with separate A-19 forms submitted for MAM, the DSHS Interpreter Services program, Vaccine Quality Improvement, and Medicaid Outreach and Access for Medicaid Children.